STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	
			B. WIN	G		04/11/2	013
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
CLADE		TI II C			ECUTIVE DR		
	BRIDGE OF CARM	EL LLU			EL, IN 46032		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	COMPLETION DATE
R000000	REGULATORT OF	CLSC IDENTIFY ING INFORMATION)		TAG			DATE
11000000							
	This visit was	for a State Resdiential	R00	00000	The following is the Plan of		
	Licensure Surv				Correction for Clare Bridge of		
		•			Carmel in regards to the		
	Survey dates:	April 4, 5, and 11,			Statement of Deficiencies for tannual survey completed on	ine	
	2013.				4-11-13. This Plan of Correct	ion	
					is not to be construed as an		
	•	Michelle Hosteter,			admission of or agreement with		
	RN-TC				the findings and conclusions in the Statement of Deficiencies,		
	Janet Stanton, RN			any related sanction and			
	Gloria Bond, R	RN			regulatory requirements. In th	is	
					document, we have outlined		
	Facility numbe				specific actions in response to identified issues. We have no		
	Provider numb				provided a detailed response to		
	AIM number: N	N/A			each allegation or finding, nor have we identified mitigating		
	Census bed ty	pe:			factors. We remain committed		
	Residential : 5	9			the delivery of quality health c services and will continue to	are	
	Total: 59				make changes and		
					improvements to satisfy that		
	Census payor	type:			objective.		
	Other: 59						
	Total : 59						
	Sample: 7						
	Campic. 1						
	These State fir	ndings are cited in					
		th 410 IAC 16.2.					
	Quality Reviev	v was completed by					
		RN on April 15, 2013.					
		, ,					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 1 of 21

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		04/11/2013	
				T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	4				
		-1.1.0		XECUTIVE DR		
CLARE B	RIDGE OF CARME	EL LLC	CARIN	IEL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R000026	410 IAC 16.2-5-1	.2(a)				
		s - Noncompliance				
		e the right to have their				
		by the licensee. The				
		ablish written policies				
	regarding residen					
	•	accordance with this				
		be responsible, through the				
		their implementation. Indiany adopted additions or				
	changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be					
	advised of residents ' rights prior to					
		nall signify, in writing, upon				
	admission and the	ereafter if the residents '				
		d or changed. There shall				
		n that each resident is in				
	•	cribed residents ' rights				
	•	es. A copy of the residents '				
		ailable in a publicly				
		The copy must be in at eand a language the				
	resident understa					
		ervation and interview,	R000026	The following is the Plan of	04/27/2013	
			1000020	Correction for Clare Bridge of	04/2//2013	
	the facility faile			Carmel in regards to the		
		nts posted in the		Statement of Deficiencies for the	he	
	•	eficit practice had the		annual survey completed on		
	potential to affe	ect 59 of 59 residents		4-11-13. This Plan of Correct	on	
	residing at the	facility.		is not to be construed as an		
				admission of or agreement wit		
	Findings includ	le:		the findings and conclusions in		
	go inioida	· - ·		the Statement of Deficiencies,	or	
	In an absorvati	on on 4/4/13 at 1 n m		any related sanction and		
		on on 4/4/13 at 1 p.m.,		regulatory requirements. In the	IS	
		esident rights posted in		document, we have outlined		
	•	k or in any of the		specific actions in response to identified issues. We have no		
	hallways on eit	her the first or second		provided a detailed response		
	floor.			each allegation or finding, nor	.	
				have we identified mitigating		
			1	1	1	

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 2 of 21

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/11/2013
	PROVIDER OR SUPPLIER		301 EX	ADDRESS, CITY, STATE, ZIP CODE KECUTIVE DR EL, IN 46032	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
	Wellness Direct p.m., she indict Rights they had displayed per to instructions. S	with the Health and stor on 4/4/13 at 1:30 ated the only Resident d posted were the ones he Ombudsmen he indicated they gave copy of the resident mission.		factors. We remain committed the delivery of quality health services and will continue to make changes and improvements to satisfy that objective. What corrective action(s) will be accomplished those residents found to have been affected by the alleged deficient practice? The Exe Director relocated the Resid Rights to an area of the facility whereby it is readily available accessible to the residents, resident's family and visitors publically accessible area with facility. The Executive Director relocated the Resid Rights on 4/5/13, during the survey and pointed out the location to the surveyor during annual survey. How will the fidentify other residents with potential to be affected by the same alleged deficient praction and what corrective action witaken? To ensure that all residents, resident's family a visitors have immediate accepted the Residents Rights, they were adily available amd access to the residents, resident's family a visitors have immediate accepted to the residents of the resident of the reside	ed for re I cutive ents ity e and ithin ents ents eng the acility the end ess to rill be sible entity enter ents end ess to re ill be enter ente

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 3 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/11/2013
	ROVIDER OR SUPPLIER		301 EX	ADDRESS, CITY, STATE, ZIP CODE ECUTIVE DR	
CLARE E	BRIDGE OF CARME	EL LLC	CARM	EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				the facility whereby they are readily available and accessib to the residents, resident's fan and visitors, in a publically accessible area within the facility. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assura programs will be put into place ~The Residents Rights will consistently be maintained in a area of the facility whereby the are readily available and accessible to the residents, resident's family and visitors, i publically accessible area with the facility. By what date will the systemic changes be implemented?4/5/13	e nily ence e? an ey n a nin

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 4 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/11/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			ECUTIVE DR	
CLARE B	RIDGE OF CARME	EL LLC		EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000036	410 IAC 16.2-5-1	` ,` ,			
	Residents' Rights				
		ust immediately consult the			
		cian and the resident 's ve when the facility has			
	noticed:	ve when the facility has			
		ecline in the resident 's			
		or psychosocial status; or			
		r treatment significantly,			
	that is, a need to	discontinue an existing			
	form of treatment				
	consequences or of treatment.	to commence a new form			
	Based on recor	rd review and	R000036	The following is the Plan of	04/27/2013
		acility failed to consult	1100000	Correction for Clare Bridge of	
		physician after an ER		Carmel in regards to the	
		om) visit for 1 of 1		Statement of Deficiencies for	the
	, ,	•		annual survey completed on	
		ved for physician		4-11-13. This Plan of Correct	ion
	notification in th	•		is not to be construed as an	u _b
	(Resident #30)			admission of or agreement with the findings and conclusions in	
				the Statement of Deficiencies	
	Findings includ	e:		any related sanction and	
				regulatory requirements. In th	nis
	The record of F	Resident #30 was		document, we have outlined	
	reviewed on 4/4	4/2013 at 2:30 p.m.		specific actions in response to	
		uded but were not		identified issues. We have no	
	_	entia with behavior		provided a detailed response	
	disturbances, d			each allegation or finding, nor have we identified mitigating	
		• .		factors. We remain committee	d to
	hypothyroidism	i (low triyrold).		the delivery of quality health c	
	The	ata a data d 0/04/0040		services and will continue to	
		otes dated 2/21/2013		make changes and	
	•	ndicated, "Rec'd		improvements to satisfy that	
	(received) repo			objective.What corrective	
	(emergency roo	om) stating resident will		action(s) will be accomplished	for
	be returning to	the facility. Papers will		those residents found to have	
	be sent with res	sident and to follow		been affected by the alleged deficient practice?~The Health	, &
	up" with resid	lent's physician. ER		Wellness Director has conduct	
	•		I	1	

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			04/11/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
CLADE F		-1.11.0			ECUTIVE DR		
CLARE E	BRIDGE OF CARMI	EL LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	"Patient discha	arge disposition form"			a nursing in-service with		
		agnoses of abdominal			nurses, regarding physician		
		•			notification after residents retu	rn	
		stool,Follow up with			from the emergency room. Ho	W	
	[Resident's phy	-			will the facility identify other		
	re-evaluation a	and further testing"			residents with the potential to l	be	
					affected by the same alleged		
	The record lac	ked documentation of			deficient practice and what		
		physician being			corrective action will be taken?		
		the ER visit for blood			~The Health & Wellness Direc		
		THE ER VISITION DIOOG			and/or Designee will conduct a		
	in stool.				weekly audit, for thirty days, of		
					residents sent out to the		
	In an interview with HWD (Health				emergency room, utilizing the		
		ctor) on 4/11/2013 at			Physician Notification Quality	nt.	
	1:20 p.m., she	•			Assessment Tool to ensure the the facility is following up and	al	
	· ·	was not able to find			consulting the physician after t	ho	
	_				resident's return to the facility	.116	
		the Resident's			following an emergency room		
	physician was	notified regarding the			visit. Nurses found to be		
	Resident's con	dition after the ER visit			non-compliant with physician		
	on 2/21/2013.				notifications/consults will be		
					properly disciplined.What		
					measures will be put in place of	or	
					what systemic changes will the		
					facility make to ensure the		
					alleged deficient practice does	;	
					not recur?~The Health &		
					Wellness Director and/or		
					Designee will conduct a weekl	y	
					audit, for thirty days, of resider		
					sent out to the emergency roo		
					utilizing the Physician Notificat	ion	
					Quality Assessment Tool to		
					ensure that the facility is follow		
					up and consulting the physicia		
					after the resident's return to the		
					facility following an emergency	′	
					room visit. Nurses found to be		
					non-compliant with physician		
					notifications/consults will be		

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 6 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMP. 04/11	
	PROVIDER OR SUPPLIE		301 EX	ADDRESS, CITY, STATE, ZIP COI ECUTIVE DR EL, IN 46032	DE T	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
				properly disciplined. How corrective actions be mo ensure the deficient pract not recur, i.e., what quality assurance programs will into place?~The Health & Wellness Director will sure audits to the Executive Director and the tof nursing non-compliant Executive Director and the wellness Director will responsible for corrective with the appropriate nurs associate. By what date we systemic changes be implemented? 4/27/2013	nitored to etice will ity be put & bmit Director of the event ce, the the Health be a actions sing will these	

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 7 of 21

		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	COMPLETED 04/11/2013	
			B. WIN			0 17 1 17	2010	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
	RIDGE OF CARME				ECUTIVE DR EL, IN 46032			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
R000090	410 IAC 16.2-5-1.	.3(g)(1-6)						
	Administration and	d Management -						
	Deficiency							
		ator is responsible for the						
	-	ent of the facility. The						
	•	the administrator shall						
		ot limited to, the following:						
	` '	division within twenty-four						
		oming aware of an unusual						
		irectly threatens the rhealth of a resident.						
		occurrence may be made						
		owed by a written report, or						
		t only that is faxed or sent						
		to the division within the						
	•	our time period. Unusual						
	•	de, but are not limited to:						
	(A) epidemic outb							
	(B)poisonings;							
	(C) fires; or							
	(D) major acciden	its.						
		not be reached, a call shall						
		mergency telephone						
	number published							
		nging for or assisting with						
	•	nedical, dental, podiatry, or						
	-	her health care services as						
	•	resident or resident's legal						
	representative.	otor approval prior to the						
		ctor approval prior to the						
		ndividual under eighteen to an adult facility.						
		acility maintains, on the						
		urate record of actual time						
	worked that indica							
	(A) employee's fu							
		irs worked during the past						
	twelve (12) month	- · · · · · · · · · · · · · · · · · · ·						
	, ,	sults of the most recent						
		the facility conducted by						
	-	ny plan of correction in						
	effect with respec	t to the facility, and any						
			L					

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		04/11/2013
			B. WING	ADDRESS SITY STATE TIP CODE	0
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE KECUTIVE DR	
CLARER	RIDGE OF CARME	=1 11 C		EL, IN 46032	
				LL, IIV 40032	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		eys. The results must be	TAG	DLI ICILICI I	DATE
	•	mination in the facility in a			
		essible to residents and a			
	notice posted of t				
		eports of surveys conducted			
		each facility for a period of			
		I making the reports ection to any member of			
	the public upon re				
	•	ervation and interview,	R000090	The following is the Plan of	04/27/2013
		not have a notice		Correction for Clare Bridge of	
	•	ng the survey results		Carmel in regards to the	
	being available, the survey book was			Statement of Deficiencies for	the
	_	accessible area, and		annual survey completed on 4-11-13. This Plan of Correct	tion
	•	t survey results were		is not to be construed as an	11011
		nis deficit practice had		admission of or agreement wi	th
	•	affect 59 of 59		the findings and conclusions i	
	•	ing in the facility.		the Statement of Deficiencies	, or
	100.001.101.0010	g a idoty.		any related sanction and regulatory requirements. In the	nie
	Findings includ	le·		document, we have outlined	113
	. mamgo morad			specific actions in response to	
	In an observati	on on 4/4/13 at 1:30		identified issues. We have no	
		s no notice posted		provided a detailed response	
	•	re the survey results		each allegation or finding, nor have we identified mitigating	
		The survey book was		factors. We remain committe	d to
	not readily acc			the delivery of quality health of	
	not readily above	coolbic.		services and will continue to	
	In an interview	with the Health and		make changes and	
		ctor (HWD) on 4/4/13 at		improvements to satisfy that objective. What corrective	
		indicated the survey		action(s) will be accomplished	d for
	book was kept			those residents found to have	
	receptionists de			been affected by the alleged	
	•			deficient practice?~The Execu	
		ign posted indicated,		Director relocated the Survey	
	•	st for survey results."		Binder, containing the the mo recent survey results, to an ar	
		receptionist had to		of the facility whereby it is rea	
	search and ask	cothers where the		available and accessible to th	- ·

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 9 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
			A. BUII B. WIN			04/11/	2013
			B. WIN		ADDRESS COMMUNICATE STR. CODE		
NAME OF F	ROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					ECUTIVE DR		
CLARE E	BRIDGE OF CARMI	EL LLC		CARME	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID NO. AND			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	survey book w	as presently located.			residents, resident's family and		
	Survey book w	as presently located.			visitors, in a publically accessi		
					area within the facility. The		
	The most rece	nt survey posted in the			Executive Director relocated		
	survey book w	as dated 2011. There			the Survey Binder on 4/5/13,		
	were no compl	aints or the most			during the survey and pointed	out	
	•	survey from 2012			the location to the surveyor du		
	posted in the s	•			the annual survey.How will the	-	
	posted in the s	divey book.			facility identify other residents		
					with the potential to be affecte	d	
					by the same alleged deficient		
					practice and what corrective		
					action will be taken?~The		
					Executive Director will ensure		
					that the Survey Binder, contain	ning	
					the the most recent survey		
					results, be maintained in an ar		
					of the facility whereby it is read	•	
					available and accessible to the		
					residents, resident's family and		
					visitors, in a publically accessi	ble	
					area within the facility. What		
					measures will be put in place of		
					what systemic changes will the facility make to ensure the	;	
					alledged deficient practice doe		
					not recur?~The Executive	.5	
					Director will ensure that the		
					Survey Binder, containing the	the	
					most recent survey results, be		
					maintained in an area of		
					the facility whereby it is readily	,	
					available and accessible to the		
					residents, resident's family and		
					visitors, in a publically accessi	ble	
					area within the facility. How wi		
					the corrective actions be		
					monitored to ensure the deficie	ent	
					practice will not recur, i.e., wha		
					quality assurance programs w		
					be put into place?~The Survey	/	
					Binder, containing the most		
			- [

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 10 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/11/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
CLARE B	BRIDGE OF CARME	EL LLC	301 EXECUTIVE DR CARMEL, IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				recent survey results will be consistently maintained in an area of the facility whereby it is readily available and accessible to the residents, resident's fan and visitors, in a publically accessible area within the facility. By what date will these systemic changes be implemented?~The Executive Director relocated the Survey Binder on 4/5/13, during the survey and pointed the location to the surveyor duthe annual survey.	s le nily

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 11 of 21

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		04/11/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
CLARE E	RIDGE OF CARME	EL LLC		ECUTIVE DR EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R000148	410 IAC 16.2-5-1. Sanitation and Sa (e) The facility shi grounds, and equicondition, in good that may adverse welfare of the res follows: (1) Each facility shi implement a writter maintenance to eupkeep of the fac (2) The electrical appliances, cords sources, fire alarm shall be maintaine functioning and celectrical codes. (3) All plumbing scomply with state (4) At least yearly systems shall be Based on obserecord review, keep living area for residents with 59 residents with 59 residents with 14, Resident #14, Resident #22) Findings including the initial Alarma at 10:45 Resident #14 hand is verbally.	afety Standards - Deficiency all maintain buildings, inpment in a clean are repair, and free of hazards by affect the health and idents or the public as a hall establish and en program for ansure the continued iility. System, including and detection systems, and detection systems, and to guarantee safe compliance with state and plumbing codes. The heating and ventilating inspected. The value of the public as a street from hazards ith confusion for 18 of a street from the facility. Resident #21, and	R000148	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for tannual survey completed on 4-11-13. This Plan of Correcti is not to be construed as an admission of or agreement wit the findings and conclusions in the Statement of Deficiencies, any related sanction and regulatory requirements. In the document, we have outlined specific actions in response to identified issues. We have no provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed the delivery of quality health care	04/27/2013 the contains the con

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 12 of 21

NAME OF PROVIDER OR SUPPLIER CLARE BRIDGE OF CARMEL LLC (XS) ID SUMMARY STATIMENT OF PRECEDITIES ACATION CLAREST CONTROL MISST BE PRECEDIDED BY FILL RECULATORY OR LSC IDENTIFYING INFORMATION) Who were married, were walking in the hallway. Resident #22 was pulling on the arm of Resident #21 to walk with him. Resident #21 to walk with him. Resident #22 was having noticeable difficulty in her gait and the staff intervened to prevent her from falling. Resident #22. became agitated and would not let go of the arm of Resident #21. During environmental rounds on 4/4/13 at 2:00 p.m., a basket of silverware with the tines of the forks, the blades of the knives sticking up out of the basket was observed on the Trains and Travels as well as the Collegiate Sports units. The basket of silverware on the Trains and Travel unit was within reach of Resident #21 and Resident #22. The basket on the Collegiate Sports unit is where Resident #14 resided. There were no staff visible in the areas at this time. During the environmental tour with the Maintenance Manager and the Executive Director on 4/5/13 at 10:10 a.m., the baskets of silverware were still within reach of the residents on the Trains and Travels and there were no staff in the area at this time. In an interview with the Executive In an interview with the		IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/11/2013
REFIX REGULATORY OR LISC IDENTIFYING INFORMATION (DATE) Who were married, were walking in the hallway. Resident #22 was pulling on the arm of Resident #21 to walk with him. Resident #21 was having noticeable difficulty in her gait and the staff intervened to prevent her from falling. Resident #21. During environmental rounds on 4/4/13 at 2:00 p.m., a basket of silverware with the tines of the forks, the blades of the knives sticking up out of the basket was observed on the Trains and Travels as well as the Collegiate Sports unit. The basket of silverware on the Trains and Travel unit was within reach of Resident #21 and Resident #12. The basket of silverware on the areas at this time. During the environmental tour with the Maintenance Manager and the Executive Director on 4/6/13 at 10:10 a.m., the baskets of silverware were still within reach of the residents on the Collegiate Sports units and there were no staff in the area at this time. In an interview with the Executive Who were married, were walking in the hallway. Resident #22 was pulling on the arm of Resident #21 to walk with the Americans and Travel and the Collegiate Sports unit is where estill within reach of the residents on the Collegiate Sports units and there were no staff in the area at this time. PREFIX TAG CROMBARETION CROSSARE PREFIXENT DAY WAS previous and will continue to make changes and improvements to satisfy that objective. What corrective action(s) will be accomplished for those residents fund to have been affected by the alleged deficient practice and what corrective action will be affected by the same alleged deficient practice and what corrective action will be taken?—The Resident Care Coordinator and/or Designee will conduct a daily audit, for thirty days, of facility and the property disciplined. What measures will be property disciplined. What measures will be property disciplined. What measures will be put in place or what systemic changes will the facility make to ensure the alledged deficient practice does not rective. T				STREET	ECUTIVE DR	
the hallway. Resident #22 was pulling on the arm of Resident #21 to walk with him. Resident #21 was having noticeable difficulty in her gait and the staff intervened to prevent her from falling. Resident #22 became agitated and would not let go of the arm of Resident #21. During environmental rounds on 4/4/13 at 2:00 p.m., a basket of silverware with the tines of the forks, the blades of the knives sticking up out of the basket was observed on the Trains and Travels unit was within reach of Resident #21 and Resident #22. The basket on the Collegiate Sports unit is where Resident #14 resided. There were no staff visible in the areas at this time. During the environmental tour with the Maintenance Manager and the Executive Director on 4/5/13 at 10:10 a.m., the baskets of silverware were still within reach of fithe residents on the Trains and Travels and the Collegiate Sports units and the Executive Director on 4/5/13 at 10:10 a.m., the baskets of silverware were still within reach of the residents on the Trains and Travels and the Collegiate Sports units and there were no staff in the area at this time. In an interview with the Executive	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON D BE COMPLETION OPRIATE
Director on 4/4/13 at 10:12 a.m., she		the hallway. Repulling on the awalk with him. having noticea and the staff in her from falling became agitate of the arm of Resident and Collegiate Sposilverware on the Unit was within and Resident Collegiate Sposilverware on the Unit was within and Resident and Re	esident #22 was arm of Resident #21 to Resident #21 was ble difficulty in her gait tervened to prevent at Resident #22 ed and would not let go desident #21. mental rounds on p.m., a basket of the tines of the forks, he knives sticking up et was observed on Travels as well as the rts units. The basket of the Trains and Travel reach of Resident #21 t22. The basket on the rts unit is where esided. There were no the areas at this time. ironmental tour with the Manager and the cotor on 4/5/13 at 10:10 ets of silverware were h of the residents on Travels and the rts units and there in the area at this time. with the Executive		make changes and improvements to satisfy the objective. What corrective action(s) will be accomplisi those residents found to he been affected by the allege deficient practice? The factonduct an in-service for the certified nursing assistants regarding resides safety and the importance leaving silverware baskets unattended in the facility neighborhoods. How will the facility identify other reside with the potential to be affective by the same alleged deficit practice and what corrective action will be taken? The Resident Care Coordinator Designee will conduct a data udit, for thirty days, of facting in the community, on varying shift ensure that the facility cert nursing assistants are follow proper safety precautions aleaving the silverware bask unattended. Certified nurs assistants found to be non-compliant with safety precautions will be properly disciplined. What measures put in place or what system changes will the facility material ensure the alledged deficite practice does not recur? Tesident Care Coordinator Designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct a data of the conduct and designee will conduct and designee will conduct and designee will conduct and designer of the conduct and designee and designer of the conduct and des	at hed for ave ed cility will ne ent of not ne ents ected ent //e r and/or ailly illity fts, to iffied owing and not kets sing y s will be nic ake to ent The r and/or ailly ailly

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 13 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
			B. WING		04/11/2013
		l .	_	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>
NAME OF P	PROVIDER OR SUPPLIER	8			
CLADE		=1.11.0		XECUTIVE DR	
ULAKE E	BRIDGE OF CARME	<u> </u>	CARIV	IEL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
_	indicated the s	ilverware should not be		community, on varying shifts,	to
	out like that an	d the staff are to put it		ensure that the facility certifie	d
		•		nursing assistants are following	ng
	away if it is cle	ali.		proper safety precautions and	l not
				leaving the silverware baskets	5
	A document titl	led Daily Assignment		unattended, utilizing the Safet	у
	Sheet provided	by the Executive		Assessment Tool. Certified	
	•	/13 at 10:45 a.m.		nursing assistants found to be	•
		oth the Collegiate		non-compliant with safety	
		ins and Travels units		precautions will be properly	4:
	•			disciplined. How will the correct	
		"Wash dishes put		actions be monitored to ensur the deficient practice will not	E
	away when do	ne don't leave		recur, i.e., what quality assura	nce
	unattended"			programs will be put into place	
				~The Resident Coordinator w	
				submit audits to the Executive	
				Director for the timeframe. In	
				event of non-compliance, the	
				Executive Director, the Health	1&
				Wellness Director and	
				the Resident Care	
				Coordinator will be responsible	е
				for corrective actions with the	
				appropriate certified nursing	
				assistant associate.By what d	
				will these systemic changes b	е
				implemented?~4/27/2013	

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
			B. WING	04/11/2013	
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			ECUTIVE DR	
CLADER	RIDGE OF CARME	ELLI C		EL, IN 46032	
OLAINE B	INDOL OF CANNE		OARWI		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000217	410 IAC 16.2-5-2				
	Evaluation - Defic	=			
		pletion of an evaluation,			
		appropriately trained staff			
		lentify and document the ovided by the facility, as			
	follows:	ovided by the facility, as			
		offered to the individual			
	· ,	appropriate to the:			
	(A) scope;				
	(B) frequency;				
	(C) need; and				
	(D) preference;				
	of the resident. (2) The services offered shall be reviewed				
		propriate and discussed by			
		acility as needs or desires e facility or the resident			
	may request a se				
		oon service plan shall be			
		by the resident, and a			
		e plan shall be given to the			
	resident upon req	· ·			
	(4) No identification	on and documentation of			
	services provided	is needed if evaluations			
	•	e initial evaluation indicate			
	no need for a cha	•			
	` '	on of medications or the			
provision of residential nursing services, or both, is needed, a licensed nurse shall be					
	involved in identification and documentation of the services to be provided. Based on observation, interview and				
			R000217	The following is the Plan of	04/27/2013
		the facility failed to	100021/	Correction for Clare Bridge of	0-7/27/2013
				Carmel in regards to the	
		rrent needs of 2 of 7		Statement of Deficiencies for t	he
		wed for updated care		annual survey completed on	
	and service pla	ns. (Residents #11		4-11-13. This Plan of Correcti	on
	and #54)			is not to be construed as an	
				admission of or agreement wit	
	Findings includ	e:		the findings and conclusions in	
				the Statement of Deficiencies,	Or

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COM			COMPL	ETED	
			A. BUII B. WIN			04/11/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
OLADE I					ECUTIVE DR		
CLARE	BRIDGE OF CARMI	EL LLC		CARIVIE	EL, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					any related sanction and		
	1. In an intervi	iew during the initial			regulatory requirements. In th	is	
		at 10:45 A.M., LPN # 1			document, we have outlined		
		dent #11 was receiving			specific actions in response to identified issues. We have no		
		es contracted through			provided a detailed response t		
		•			each allegation or finding, nor	O	
	an outside age	ilicy.			have we identified mitigating		
	The aller of	and was not decreed			factors. We remain committee	l to	
		cord was reviewed on			the delivery of quality health ca		
		5 P.M. Diagnoses			services and will continue to		
	included, but w	vere not limited to,			make changes and		
	Lewy body der	mentia with delusions,			improvements to satisfy that		
	bipolar disorde	er, bilateral retinal			objective.What corrective	£	
	-	evere arthritis with			action(s) will be accomplished those residents found to have	TOr	
		ature of the spine), and			been affected by the alleged		
	• • • •	with degenerative disc			deficient practice?~The Health	۰.&	
	disease of the	•			Wellness Director updated	. ~	
	disease of the	cervical spirie.			the Personal Service Plans for		
	A = O = = t = = = t f =	was from the Lieuwice			resident #11 and resident #54		
		rm from the Hospice			4/5/13, during the annual surv	еу	
	, ,	12/10/12, indicated			and submitted the		
		as admitted to that			updated Personal Service Plan	าร	
	agency's servi	ces on that date.			to the surveyor. The updated Personal Service Plans will be		
					maintained in resident #11 and		
	The April, 2013	3 physician order recap			resident #54's medical		
	(recapitulation)) sheet listed orders			chart, within the facility and		
	l ' '	out were not limited to,			followed by the facility. How w		
		12/12/11Bed alarms			the facility identify other reside		
		3/1/13"]; and Hoyer			with the potential to be affecte	d	
	_	ft with assistance of 2			by the same alleged deficient practice and what corrective		
	(staff).	acciotarioc di Z			practice and what corrective action will be taken?~The Hea	lth	
	(3(a)).				& Wellness Director will meet	101	
	On 4/4/42 at 4	2:10 D.M. the resident			weekly with the Resident Care	!	
	On 4/4/13 at 12:10 P.M., the resident				Coordinator and bi-weekly with		
		sitting in a high-back			the therapy team and commur		
		a table in his unit's			leadership to discuss any resid		
	_	ea. A CNA was sitting			changes of condition. After the		
	next to the resi	ident, feeding him his			meetings the Health & Wellnes	SS	

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 16 of 21

NAME OF PROVIDER OR SUPPLIER CLARE BRIDGE OF CARMEL LLC CARMEL, IN 46032 SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICENCE) TAG (EACH DEPICENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC (IDENTIFYING INFORMATION) LIUNCH meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachments Legally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosis Resident is on [name of Hospice agency] Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staff Since assessment, the resident is easily directed to the	i î			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER CLARE BRIDGE OF CARMEL LLC LX0, ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG LUNCH meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment and does not appear to be a safety risk to self or staffSince assessment the resident is now able to stand by himself and is easily directed to the	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 00		00	COMPLETED		
TAG SUMMARY STATEMENT OF DEPICIENCIES (AA) ID SUMMARY STATEMENT OF DEPICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) I Lunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silvenware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the						·	04/11/	2013
CLARE BRIDGE OF CARMEL LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) LIUNCH meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthrifts. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment, the resident is now able to stand by himself and is easily directed to the				B. WII.		ADDRESS CITY STATE ZIP CODE		
CLARE BRIDGE OF CARMEL LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) I lunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the	NAME OF P	PROVIDER OR SUPPLIEF	₹					
NA ID SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Director will packed resident Director will packed resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? - The Health & Wellness Director will update resident was not able to stand by himself and is easily directed to the Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? - The Health & Wellness Director will meet weekly with the therapy team and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? - The Health & Wellness Director will work with the nursing team to ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team to will medical cart, being followed by the nursing team to ensure that the most recent will not record in the program will be put into place? - The Health & Wellness Director will work with the nursing team to ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team to ensure that the most recent and accurate copy is in the re	CLARE F	RIDGE OF CARMI	FLLIC					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Ilunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the								
Iunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment, the resident is now able to stand by himself and is easily directed to the						PROVIDER'S PLAN OF CORRECTION		
lunch meal, which was a puree consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident and source plans and ensure that the most recent and accurate recopy is in the resident's medical cart, being followed by the nursing team. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? -The Health & Wellness Director will meet weekly with the therapy team and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate voy is in the resident's medical cart, being followed by the nursing team. How will the facility make to ensure the leficient practice will be facility make to ensure the deficient practice will be facility make to ensure the deficient practice will be facility make to ensure the deficient practice opts in the resident's medical cart, being followed by the nursing team to ensure that the most recent and accurate copy is in the resident smedical cart, being followed by the nursing team to ensure that the most recent accurate.		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
consistency. A Hospice aide arrived and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the	TAG		<u> </u>	-	TAG	•		DATE
and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment, the resident is now able to stand by himself and is easily directed to the								
and assumed the task of feeding the resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		consistency. A	A Hospice aide arrived				, d	
resident. The resident was not able to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		and assumed t	the task of feeding the					
to hold silverware in his hands. A Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		resident. The	resident was not able					
Hoyer lift sling was observed under his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment, the resident is now able to stand by himself and is easily directed to the		to hold silverwa	are in his hands. A					
his body. A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety resident is now able to stand by himself and is easily directed to the								
A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the			The obodived diluci				ity	
A "Personal Service Plan," with a date of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		i iio buuy.					-	
of 2/12/13, was found in the clinical record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		A !!Dama O	amiaa Dlam II wille a date					
record. Information on the Service Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the			•				tor	
Plan included: " Bilateral retinal detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		· ·				-		
detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and community leadership to discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will update resident Personal Service Plans are in the							-	
detachmentsLegally blind in right eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the discuss any resident changes of condition. After these meetings the Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will update resident Personal Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team.How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will update resident Personal							m	
eyesevere arthritis. He also has degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		detachments	Legally blind in right				of	
degenerative stenosis with MRI confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the								
confirmation of spinal stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		•				-		
stenosisResident is on [name of Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the Service Plans and ensure that the most recent and accurate copy is in the resident's medical cart, being followed by the nursing team. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will work with the nursing team to ensure that the most recent Personal Service Plans are in the		_				will update resident Personal		
Hospice agency]Assist of one required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the			-				the	
required for showering and safety needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the being followed by the nursing team. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ~The Health & Wellness Director will work with the nursing team to ensure that the most recent Personal Service Plans are in the			=			most recent and accurate copy	y is	
needs. He was assist with two when he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the								
he entered gero-psych [sic] but has improved since initial assessment and does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		•	•					
the deficient practice will not recur, i.e., what quality assurance programs will be put into place? self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the							•	
recur, i.e., what quality assurance programs will be put into place? self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the		he entered ger	o-psych [sic] but has				=	
does not appear to be a safety risk to self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the programs will be put into place? ~The Health & Wellness Director will work with the nursing team to ensure that the most recent Personal Service Plans are in the		improved since	e initial assessment and			· · · · · · · · · · · · · · · · · · ·	nce	
self or staffSince assessment, the resident is now able to stand by himself and is easily directed to the ~The Health & Wellness Director will work with the nursing team to ensure that the most recent Personal Service Plans are in the		does not appe	ar to be a safety risk to					
resident is now able to stand by himself and is easily directed to the will work with the nursing team to ensure that the most recent Personal Service Plans are in the		self or staffS	ince assessment, the			· · · · · · · · · · · · · · · · · · ·		
himself and is easily directed to the ensure that the most recent Personal Service Plans are in the								
I Personal Service Plans are in the I			•			ensure that the most recent		
hathroom by associates. He does		bathroom by associatesHe does walk with his head down to where his chin can touch his neckHe has been ambulatory a few days prior to move in and is now ambulating				Personal Service Plans are in	the	
resident's medical data and being							•	
lonowed by the haroling team.by							Зу	
24/27/2012								
move in and is now ambulating						7/21/2010		
around the community by himself"		around the cor	nmunity by himself"					
This Service Plan also listed the		This Service P	lan also listed the					
services to be provided to the		services to be	provided to the					

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	00	COMPL	ETED	
			B. WIN			04/11/	2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAIVIE OF F	ROVIDER OR SUPPLIER			301 EXI	ECUTIVE DR		
	BRIDGE OF CARME	EL LLC		CARME	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		facility. The services					
	· · · · · · · · · · · · · · · · · · ·	vere not limited to, the					
	_	vide direct physical					
		le eating (e.g. prompts					
		nstration and hand					
		direction to sit) as					
		ident is able to perform					
		isks with physical					
		needed: putting					
	on/taking off cl	othing,					
	_	stening clothing, putting					
	on/taking off so	ocks/shoes;Resident					
	is able to perfo	rm the following					
	showering task	s with physical					
	assistance as i	needed: shampooing					
	hair, washing ι	ıpper body, washing					
	lower body;f	Resident needs help in					
	the bathroom:	assist with pulling					
	pants up and d	lown, assist with					
	handling of toil	et paper and wiping					
	_	ack;Resident is					
		oladder; Resident is					
		owel;Encourage					
		handrails in bathroom,					
		ident to lock wheelchair					
	_	Resident uses bed					
	alarm"						
	The Service PI	an did not address the					
		ecline in the resident's					
	_	ionno longer able to					
		other ADL (Activity of					
	Daily Living) ca	` •					
		for transfers, or need					
		cility or Hospice staff.					
	to be led by lat	unty of Flospice staff.					

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 18 of 21

i î		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IG	00	COMPL	ETED	
			B. WING			04/11/	2013
			ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹	30	01 EXE	ECUTIVE DR		
CLARE E	BRIDGE OF CARMI	EL LLC			L, IN 46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREI	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	There was no i	indication what services					
	the hospice ag	ency was providing,					
	only that the re	esident was "on"					
	hospice. The	Service Plan was not					
	•	the bed alarms were					
	discontinued.						
	In an interview	on 4/5/13 at 10:40					
		th Wellness Director					
	•	was the one who wrote					
		ans and had done so					
		e second week in					
		12. She indicated she					
	· ·	required, including					
	•	s a significant change.					
		she would need to					
		other files to determine					
		s Service Plan had					
	•	to reflect his current					
	status and nee	eas.					
	On 4/11/13 at	11:45 A.M., the Health					
		ctor provided a Service					
		peen completed on					
		P.M. She indicated					
		und any other Service					
		•					
	Plan prior to this one, or after the one that had been completed on 2/12/13.						
	and that been						
	2. The record	review for Resident					
	#54 was comp	leted on 4/4/13 at					
	•	agnoses included, but					
		d to, depression,					
	dementia and	-					
	25		<u> </u>				

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 19 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		î ′	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		MPLETED 111/2013
			B. WING			11/2013
NAME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZII	P CODE	
CLARE	BRIDGE OF CARM	FLLIC		ECUTIVE DR EL, IN 46032		
				, 114 70002		(775)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE
	subarachnoid hemorrhage.					
		eago.				
	In the clinical r	ecord the most recent				
	service plan fo	or Resident #54 was				
	•	2. The service plan				
		rding nutrition for the				
	_	reed foods, be alert to				
	· '	choking while eating.				
	0	staff attention and				
	assistance wh	ile eating. Allow for				
	extended mea	I time. Be alert to				
	weight loss"					
	The nursing notes indicated on 1/9/13					
	through 1/12/1	3, the resident had				
	episodes of vo	miting which they				
	attributed to th	e flu. The nurses				
	notes indicated	d on 1/16/13 2:40 p.m.,				
	"Res [reside	nt] had problems [sign				
	for with] swalld	owing liquids order for				
	speech therap	y to eval [evaluate]"				
		s orders indicated on				
	1/21/13 the resident was to be started					
	on nectar thick	cenea liquias.				
	lo on interview	with the Health and				
		with the Health and				
		ctor (HWD) on 4/11/13				
		indicated they updated				
	-	in. She also indicated				
		nt service plan the as dated 11/28/12. The				
		rovided by the HWD				
		/13. The service plan				
	maicated the r	esident was on nectar				

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 20 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 04/11/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-
CLARE E	BRIDGE OF CARME	EL LLC		ECUTIVE DR EL, IN 46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	REACH CORRECTIVE OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION

State Form Event ID: 8CNV11 Facility ID: 010416 If continuation sheet Page 21 of 21